The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street
Boston, MA 02108
(617) 973-0971
www.mass.gov/dph/dentalboard

Facility Permit D-H

(See 234 CMR 6.08 Effective August 20, 2010)

Facility Requirements for Dental Offices Using Mobile and/or Portable Anesthesia Services

Application Instructions

Each dental facility or practice site utilizing mobile or portable anesthesia services is required to have a Facility Permit D-H. The operating dentist shall be responsible for ensuring that the qualified dental anesthesiologist has the proper individual anesthesia permit and a current facility permit D-P (see.6.09) issued by the Board, and that the portable anesthesia service is appropriately permitted and equipped in accordance with 234 CMR 6.00 for the level of pain control and/or sedation to be provided.

The operating dentist shall be responsible for ensuring that the qualified dental anesthesiologist has the proper anesthesia permit and that the portable anesthesia service is appropriately permitted for the level of pain control and/or sedation to be provided.

If you already hold a current Facility Permit D for the level of anesthesia you plan to have administered by a Portable Dental Operation, please do not submit this application.

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Application –Facility Permit D-H

1. APPLICANT NAME _____MA DN Lic. # _____
Last First MI

2. FACILITY ADDRESS: _____
No. Street Unit #

_____
City/Town State Zip Code

3. BUSINESS NAME/DOING BUSINESS AS: _____

4. TELEPHONE NUMBER-DAY: _____CELL:_____FAX: _____

5. EMAIL ADDRESS: _____

6. **PRACTICE OWNER** (if different from applicant)

Name:_____MA Dental Lic. #_____

Telephone:_____Email:_____

7. **FACILITY DENTAL DIRECTOR** (if applicable – see 234 CMR 5.02 (3))

Name:_____MA Dental Lic. #_____

Telephone:_____Email:_____

8. **TYPES OF ANESTHESIA**

TYPE(S) OF ANESTHESIA AND/OR SEDATION TO BE ADMINISTERED (Check all that apply.)

Nitrous Oxide- Oxygen Only _____
Nitrous Oxide-Oxygen + Oral Sedative(s) _____
Oral Sedation Only _____
I.V. Sedation _____
General Anesthesia and Deep Sedation _____
Other route of administration: _____

FACILITY PERMIT D-H APPLICATION ATTACHMENTS

□ **Attachment 1**: Personal or business check or money order made payable to THE COMMONWEALTH OF MASSACHUSETTS in the amount of $180. **All fees are nonrefundable and nontransferable**.

□ **Attachment 2**: Required Equipment and Emergency Drugs, as applicable (**see form attached**)

□ **Attachment 3**: Copy of a schedule and log demonstrating the regular inspection of all emergency drugs and equipment for administration of anesthesia at the office site, including the date(s) and name of person who last checked drugs and equipment and the results of the checks, including that of the condition of equipment according to manufacturers' specifications.

APPLICANT ATTESTATION: I _____HEREBY CERTIFY,
Print Full Name of Applicant

UNDER THE PAINS AND PENALTIES OF PERJURY, THAT:

- **ALL INFORMATION PROVIDED IN THIS APPLICATION IS ACCURATE AND TRUE; I HAVE READ AND UNDERSTOOD THE STANDARDS AND REQUIREMENTS FOR FACILITY PERMITS AS PROMULGATED BY THE BOARD ON AUGUST 20, 2010 AT 234.CMR 6.03 AND 6.08**

- **I READ AND UNDERSTOOD THE REQUIREMENTS FOR ADMINSTRATION OF GENERAL ANESTHESIA, DEEP SEDATION, MODERATE SEDATION, MINIMAL SEDATION AND NITROUS OXIDE-OXYGEN AT 234 CMR 6.11-6:14 AND THAT THE QUALIFIED DENTAL ANESTHESIOLOGIST HAS THE PROPER ANESTHESIA PERMIT AND THAT THE PORTABLE ANESTHESIA SERVICE IS APPROPRIATELY PERMITTED FOR THE LEVEL OF PAIN CONTROL AND/OR SEDATION TO BE PROVIDED FOR THE OFFICE.**

- **I AM CURRENTLY, AND WILL CONTINUE TO BE, IN COMPLIANCE WITH ALL STATUTES, RULES, AND REGULATIONS PERTAINING TO THE PRACTICE OF DENTISTRY IN THE COMMONWEALTH OF MASSACHUSETTS AS REQUIRED BY LAW.**

SIGNATURE OF APPLICANT: _____**DATE**:_____

APPLICATION IS VALID ONLY 90 DAYS UPON RECEIPT.

Attachment 2

AT A MINIMUM, A FACILITY THAT HOSTS A MOBILE OR PORTABLE DENTAL ANESTHESIA SERVICE WILL BE REQURED TO HAVE THE FOLLOWING EQUIPMENT AND DRUGS

EQUIPMENT REQUIRED	DATE LAST INSPECTED
Alternative light source for use during power failure	
Ambu-bag or portable bag-mask ventilator	
Automated or manual external defibrillator, including batteries and other components	
Disposable CPR mask (pediatric and adult)	
Disposable syringes (assorted sizes)	
Latex free tourniquet	
Oxygen (portable Cylinder E tank) pediatric and adult masks capable of giving positive pressure ventilation including bag-valve-mask system	
Sphygmomanometer and stethoscope (pediatric and adult)	
Suction	

EMERGENCY DRUGS AND DRUG CLASSIFICATIONS REQUIRED BY 234 CMR 6.08 TO BE PROVIDED AND MAINTAINED AT SITE

REQUIRED DRUGS	NAME OF DRUG	DOSAGE	EXPIRATION DATE
Acetylsalicylic acid (rapidly absorbable form)	[redacted]		
Ammonia inhalants		[redacted]	
Antihistamine			
Bronchodilator			
Epinephrine pre-loaded syringes (pediatric and adult)	[redacted]		
2 Epinephrine ampules			
Oxygen			
Vasodilator			
Vasopressor			

NAME(S) OF DENTIST(S)/ANESTHESIOLOGIST(S) WHO WILL BE ADMINISTERING ANESTHESIA AT THIS FACILITY	LICENSE NUMBER	ANESTHESIA PERMIT NUMBER	ACLS/BLS CERTIFICATION EXPIRATION DATE
Dental Director:			

Attachment 2 (page 2)

NAME(S) OF DENTAL/SURGICAL ASSISTANT(S)	LICENSE NUMBER	CPR/BLS CERTIFICATION EXPIRATION DATE

SIGN AND SEND THIS APPLICATION AND ALL REQUIRED ATTACHMENTS TO:

BUREAU OF HEALTH PROFESSIONS LICENSURE

BOARD OF REGISTRATION IN DENTISTRY

250 WASHINGTON ST., BOSTON, MA 02108

KEEP A COPY OF THIS APPLICATION AND ALL ATTACHMENTS FOR YOUR RECORDS

INCOMPLETE APPLICATIONS WILL BE RETURNED.